College of Pharmacists of Manitoba

200 TACHE AVENUE, WINNIPEG, MANITOBA R2H 1A7
TELEPHONE (204) 233-1411 FAX: (204) 237-3468 E-MAIL: info@cphm.ca

APPLICATION FOR AUTHORIZATION TO PRESCRIBE A DRUG INCLUDED IN SCHEDULE 3 TO THE PHARMACEUTICAL REGULATION FOR SELF-LIMITING CONDITIONS (NOT INCLUDING SMOKING CESSATION)

I hereby make application to the College of Pharmacists of Manitoba for authorization to prescribe a drug included in the category for a condition (see below) listed in Schedule 3 to the Pharmaceutical Regulation.

____

(Title) (Last Name) (First Name) (Middle Name(s))

____

(Mailing Address) (City) (Province) (Postal Code)

____

(Telephone Number) (Email Address) (College Licence Number)

Please read carefully:

To be eligible to apply for certification of authorization to prescribe a drug included in the category for self-limiting conditions listed in Schedule 3 to the Regulation, with the exception of smoking cessation, a pharmacist must:

- be a licensed, practicing member with the College of Pharmacists of Manitoba; and
- have successfully completed the Self-Limiting Conditions Independent Study Program for Manitoba Pharmacists, including viewing the Fundamentals of Self-Limiting Conditions Prescribing for Manitoba Pharmacists presentation.

Please note: A certificate of authorization can be issued for either the self-limiting conditions with the exception of smoking cessation; smoking cessation; or for both the self-limiting conditions and smoking cessation. This form is to be completed by applicants who want to prescribe drugs in Schedule 3 to the Regulation for atopic dermatitis, allergic contact dermatitis, irritant contact dermatitis, urticaria; acne vulgaris; tinea pedis; candidal stomatitis; unspecified haemorrhoids without complication; vasomotor and allergic rhinitis; seborrhoeic dermatitis (excluding pediatric); recurrent oral aphthae; and vomiting of pregnancy, unspecified. To apply for authority to prescribe a drug included in Schedule 3 the Regulation for smoking cessation, please see the appropriate application form on www.cphm.ca

APPLICATION FOR AUTHORIZATION
TO PRESCRIBE A DRUG INCLUDED IN SCHEDULE 3 TO THE PHARMACEUTICAL REGULATION FOR SELF-LIMITING CONDITIONS (NOT INCLUDING SMOKING CESSATION)

To apply to prescribe the drugs for the self-limiting conditions listed in Schedule 3 to the Regulation, with the **exception of smoking cessation**, please attach a copy of the following required document:

- □ Certificate of successful completion of the Self-Limiting Conditions Independent Study Program for Manitoba Pharmacists, issued by Advancing Practice

Professional Declaration

In the matter of my application to the College of Pharmacists of Manitoba to prescribe a drug included in the category for a condition (with the exception of smoking cessation) listed in Schedule 3 to the Pharmaceutical Regulation

I, ____
(Applicant's Full Name)

of ______________________ in the Province of ______________ declare that
(City or Town) (Province)

1. as a regulated member of the College of Pharmacists of Manitoba, licensed as a practicing member, I will abide by the standards of practice, practice directions, and other legislation and requirements that apply to prescribing and restrict my practice to those areas in which I am competent;
2. I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications;
3. I have successfully completed the applicable training program(s) approved by Council and possess the necessary knowledge and skill to prescribe safely and effectively for the self-limiting conditions for which I have applied;
4. the status of my eligibility for certification of authorization to prescribe a drug included in the category for a condition (with the exception of smoking cessation) listed in Schedule 3 to the Pharmaceutical Regulation is subject to audit and that false or misleading statements concerning my qualifications may be considered grounds for a complaint of unprofessional conduct; and
5. I will only prescribe in an area that maintains patient confidentiality and privacy to the extent required.

I make this professional declaration conscientiously believing it to be true.

Declared this _______ day of ________________, 20_________.
(Date) (Month) (Year)

____
(Signature)